Role of the Department of Insurance

Prompt pay reporting and the "clean claim" complaint process for

Medicaid Managed Care Organizations

Statutory Quarterly Reporting

DOI receives prompt payment self-reporting data from MCOs.

- Submitted to the Health & Life Division according to statutory timeframes.

If reporting standards are not met, DOI takes regulatory action.

- DOI will meet with the company and may request a corrective action plan or levy a fine.

KRS 304.17A-722(3)
Reporting timeframes for claims payment practices

Calendar quarter in which claims are incurred	Deadline for reporting to DOI	Corrective action implemented, if needed	Impact of corrective action demonstrated in reporting
Jan. – March 2013	Sept. 30, 2013	Oct. – Dec. 2013	June 30, 2014
April – June 2013	Dec. 31, 2013	Jan. – March 2014	Sept. 30, 2014
July – Sept. 2013	March 31, 2014	April – June 2014	Dec. 31, 2014
Oct. – Dec. 2013	June 30, 2014	July – Sept. 2014	March 31, 2014

KRS 304.99-123 –

Penalties for noncompliance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123

- Allows the Department of Insurance to issue fines of up to $1,000 per day or 10 percent of the unpaid claim (whichever is greater) if an insurer fails to pay, deny or contest:
  - At least 95 percent of the clean claims received during a calendar quarter; or
  - At least 90 percent of the total dollar amount of the clean claims received by an insurer during a calendar quarter.
- A separate fine of up to $10,000 may be levied for willful and knowing violations or if an insurer has a pattern of repeated violations.

KRS 304.17A-702 –
Claims payment timeframes – Duties of insurer

- Requires “clean” claims to be paid, contested or denied within 30 days of receipt.

Note: A “clean” claim is a properly completed billing instrument – paper or electronic – including the required health claim attachments and submitted in the form outlined in statute.

KRS 304.17A-700

"Clean Claim"

means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

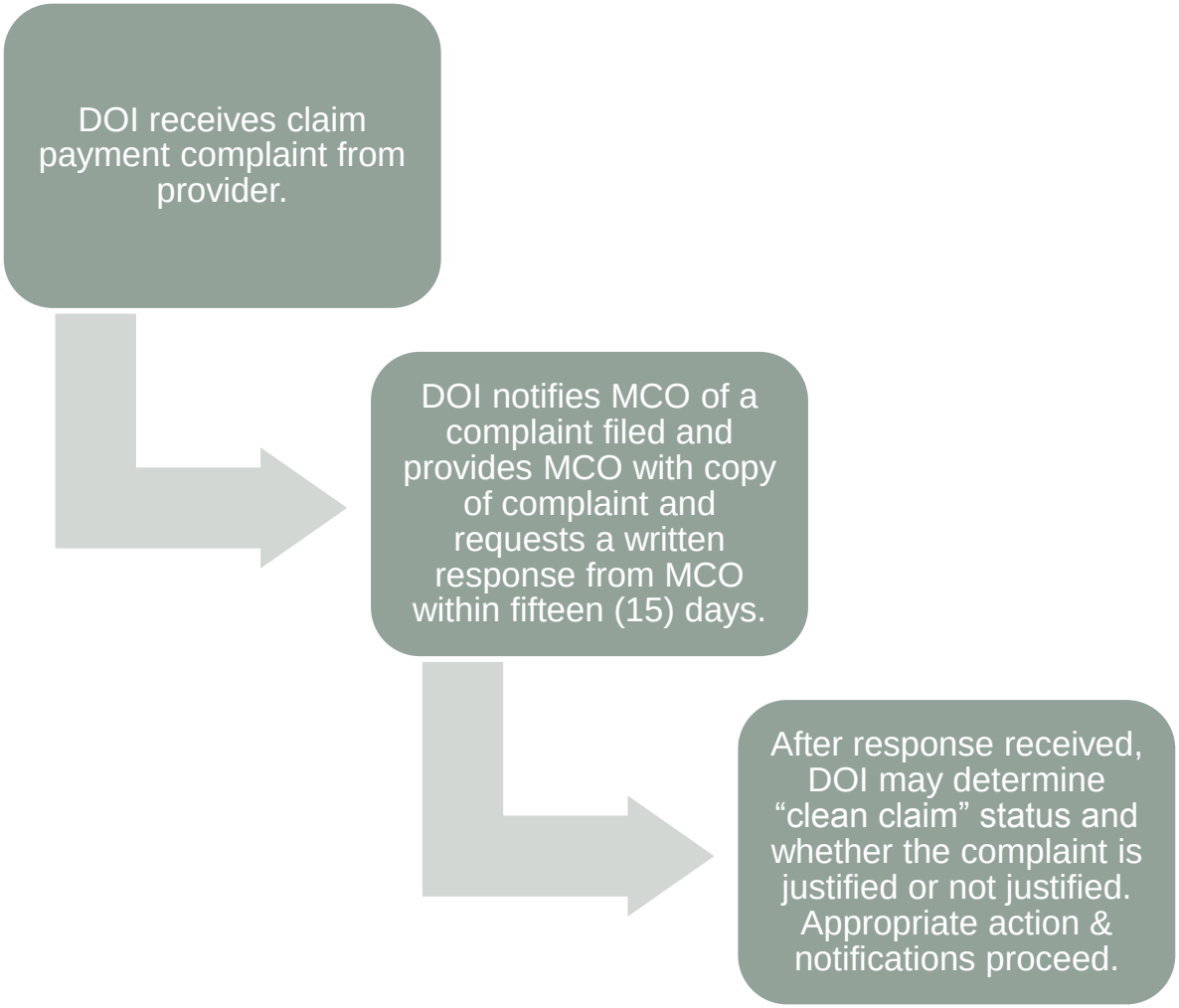
(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

KRS 304.17A-730 – Payment of interest for failing to pay, denying or settling a clean claim as required

- Requires insurers to pay interest at the applicable rate for failure to pay, deny or settle a claim within the 30-day period established in KRS 304.17A-702.
  - This interest attaches as a matter of law.

Complaint Process



Submitting a clean claim complaint

- Paper
  - Kentucky Department of Insurance Health Care Provider “CLEAN CLAIM” Complaint Form and submit all supporting documentation

- Electronic
  - DOI website allows electronic submission
    - DOI website http://insurance.ky.gov go to Tab—File a Complaint—Clean Claim Electronic Submission---the next step requires you to set up an E-Services Account—step by step instructions with graphics are provided in establishing an E-Services account.

DOI Consumer Protection Process

- Receive the complaint, review for attached documentation
- Enter the complaint by the individual member's name and assign a case number
  - Review the documentation to identify the number of claim lines associated with the individual member and identify which claims are in need of review.
  - Determine if additional information is needed from complaint and request if appropriate

DOI Consumer Protection Process

- Notify the MCO in writing that a complaint has been received and provide a copy of the complaint to the MCO
  - The MCO is required to respond in writing to DOI within 15 days
- Upon receipt of the MCO's response, DOI will review and request additional information if necessary
  - DOI will make determination:
    - Clean Claim
    - Justified
    - Not Justified

DOI Consumer Protection Process

- Notify the Provider and MCO of the determination
- If MCO is responsible for paying the claim, the claim is required to be paid with 30 days with interest if applicable
- MCO provides to DOI verification of payment at time of payment
- If either party disagrees with DOI determination, there are appeals processes which follow the Department of Medicaid Services appeals and hearings processes.

Thank you

The Department of Insurance appreciates the cooperation of the Healthcare Providers, the Medicaid Managed Care Organizations and the Department for Medicaid Services as we collectively and cooperatively work to manage and improve the payment of claims and the delivery of healthcare for our citizens in the Commonwealth.

Please feel free to contact us if you have any questions as we move forward.